UK government and doctors agree to end "blame culture"

Jacqui Wise *London*

The UK government and the medical profession have called for an end to the blame culture of the NHS in a joint statement that aims to raise standards of care.

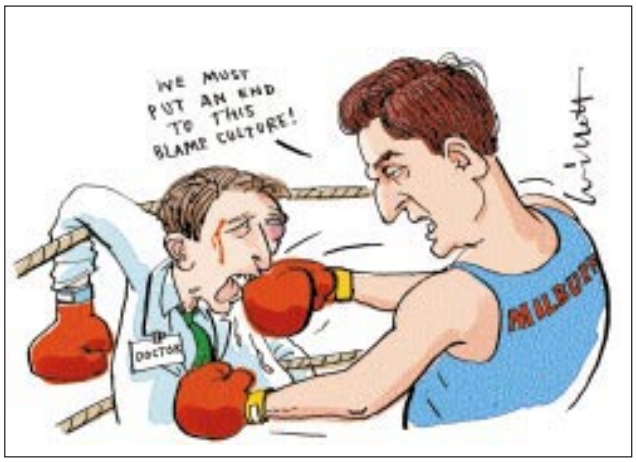
The declaration, drawn up by the chief medical officer for England, Professor Liam Donaldson, aims to put quality first in the NHS. It has been signed by leading members of the medical establishment, including Donald Irvine, president of the General Medical Council, Professor Denis Pereira Gray, chairman of the Academy of Medical Royal Colleges, and Barry Jackson, president of the Royal College of Surgeons.

The document calls for the NHS to be more open in the way it deals with medical mistakes and to "recognise that honest failure should not be responded to primarily by blame and retribution, but by learning and by a drive to reduce risk for future patients."

It sets out a shared commitment to work to minimise errors, to reduce their impact when they do occur, to learn from mistakes, and to make improvements in clinical quality—a cornerstone of reform in the NHS.

Seven pledges of new joint document on NHS

- To continue to show a commitment from the top to implementing the programme of quality assurance and quality improvement
- To take every opportunity to involve patients and their representatives in decisions about their own care and in the planning and design of services
- To work towards providing valid, reliable, up to date information on the quality of health services
- To work together in determining clinical priorities
- To create a culture in the NHS that is open and participative, where learning and evaluation are prominent, and which recognises safety and the needs of patients as paramount
- To recognise that in a service as large and complex as the NHS things will sometimes go wrong. Without lessening commitment to safety and public accountability of services, the signatories pledge to recognise that honest failure should not be responded to primarily by blame and retribution, but by learning and by a drive to reduce risk for future patients
- To recognise that the professions, the government, and the public share a common interest and commitment to improving the quality of services for patients



Launching the declaration, the health secretary, Alan Milburn, said: "Medicine is not a perfect science. Even the best doctors can make the worst mistakes. Reducing errors and improving care means changing how the NHS works to minimise risks for patients.

"It also means ending the blame culture. Of course the small minority of bad doctors should be dealt with promptly and fairly. But the NHS needs to be more open when things go wrong so that it can learn to put them right. It needs to support good doctors, not penalise them."

Professor George Alberti, president of the Royal College of Physicians of London and one of the document's signatories, said: "I think it is a real step in the right direction. It's a realisation by the government that doctors are working their butts off and that 99% are effective, hard working people." □

A Commitment to Quality, a Quest for Excellence is available on the Department of Health's website at www.doh.gov.uk/whatsnew/index.html

Hospitals must inform patients of errors

Deborah Josefson *San Francisco*

Hospitals in the United States have been told that they must inform patients of medical errors, in new rules issued by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a non-profit making group that monitors 11 000 hospitals and 19 000 healthcare organisations nationwide.

Hospitals that do not comply may lose their accreditation or face steep fines. Currently only Veteran's Administration hospitals, which care for US armed forces veterans, are required to inform patients of medical errors.

The new rules took effect on 1 July and are intended to increase patient safety. The regulations were developed in response to a 1999 report from the Institute of Medicine estimating that preventable medical errors kill between 44 000 and 98 000 hospital patients each year (*BMJ* 1999;319:1519). The institute's report found that most of these errors were the result of system problems rather than poor performance by individual providers.

A congressional report additionally found that over 95% of medical errors went unreported. Congressional figures also showed that medication errors, such as missed dosages, double dosages, and dangerous drug interactions, are responsible for 777 000 deaths or injuries among patients annually.

Under the new commission regulations hospitals must actively prevent medical errors and must design patient care processes taking account of safety issues. Changes in organisation and refinement of information management systems will be key components of reducing medical error.

Changes such as internal checks to ensure that the correct patient receives the correct dose of the correct medication will be instituted. Drug orders will be linked to pharmacy records so that drug interactions can be checked for. Hospitals and doctors will be encouraged to report all medical errors, regardless of whether a patient was harmed by them. Additionally, healthcare providers will be required to inform patients if they have been harmed in the course of diagnosis or treatment.

The new standards represent a radical departure from the traditional culture of medicine. Doctors and hospitals customarily fail to disclose medical errors to patients. Indeed, a web of silence about medical errors traditionally prevails, not least because of fear of malpractice litigation.

Professions have also tended to protect their own members from outside critics. It is hoped that the increased disclosure may reduce malpractice lawsuits by promoting better communication between doctors, hospitals, professional staff, and patients and their families. Studies have shown that patients who have good relationships with their doctors are more satisfied with their care and less likely to sue, even when the doctor or hospital is at fault. □